

2016 SPECIAL NEEDS CAMPER APPLICATION: GROTONWOOD

IMPORTANT: This application will not be considered if it is returned incomplete, or without the Medical Record and **required non refundable deposit of \$250.00 per session for summer camp or \$150.00 per session for weekend holdover.** NOTE:

Holdover weekends are **only** available to Grotonwood campers attending two consecutive weeks of camp. Campers are limited to 2 consecutive sessions of camp; no more than 4 sessions per summer.

FOR OFFICE USE ONLY

Date Rec'd _____

Amt. Rec'd _____

Check #: _____

SNC OK'd _____

Date Approved: _____

CAMPER INFORMATION (Note: This is the address ALL correspondence will be mailed to) **PLEASE PRINT NEATLY on ALL PAGES.**

Camper's Name: _____

Phone Number: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

() Male () Female Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Social Security #: _____

Type of Residence:

- Private
- Group Home
- Institution
- Other

T-Shirt Size

- Adult Small
- Adult Medium
- Adult Large
- Adult X-Large
- Adult XX-Large

CONTACT INFORMATION (During the Year AND While at Camp)

Contact Person #1: _____ Day Phone: _____

Relationship to Camper: _____ Night Phone: _____

If not available, please call:

Contact Person #2: _____ Day Phone: _____

Relationship to Camper: _____ Night Phone: _____

Person/Agency Responsible for Transportation

Name: _____ Phone: _____

REGISTRATION INFORMATION: GROTONWOOD

Please Register for the Following

(NOTE: At Grotonwood, HOLDOVER weekends are available ONLY to campers attending 2 consecutive weeks of camp.)

Camper is attending session(s) at **GROTONWOOD**

Dates: _____ Program Title _____

If possible, camper would like to room with: _____

I understand that the REGISTRATION Fee is non-refundable, non-transferable; and that fees for campers leaving before the end of the session will be pro-rated and refunded ONLY in the case of illness or injury.

Make Check payable to GROTONWOOD. Mail Application, Medical Record & Deposit to: 167 Prescott St., Groton, MA 01450

Enclosed is my registration fee (\$250 per session for each week, \$150 per holdover session) of \$_____.

If the camper is being paid for by an agency, please provide:

Agency Name: _____

Contact Person: _____

Phone #: _____

Amount: \$ _____

The following information will allow us to plan appropriate activities that will help insure a positive camp experience. Please be specific in your answers, and **use another piece of paper if necessary**. Time spent now will save you time later.

Grotonwood is a ministry for children, families, and for adults with special needs. The normal camp ratio of counselors to campers is one to eight (1:8). The camp programs at Grotonwood that deal with special needs adults are based upon a 1:4 staff to camper ratio, and daily activities run from 8:00 a.m. to 9:00 p.m. Activities include: Swimming, boating, crafts, nature hikes, games/recreation, campfires, singing, and possible some day trips for certain groups. Your camper **MUST** meet the following Minimum Abilities list in order to participate in our programs. If you have questions, call the camp office BEFORE you continue with this application.

MINIMUM ABILITIES LIST

ALL CAMPERS MUST MEET THE ABILITIES LISTED BELOW. Misrepresentation of the applicant may be cause for dismissal from camp without refund. AFTER READING, PLEASE SIGN BELOW.

ATTENDING GROTONWOOD:

MOBILITY:

Must be able to walk without the assistance of a wheelchair* or walker* (limited cane use may be appropriate). Terrain is rough (hills, rocks, dirt roads and paths, stumps and roots, etc.). *A few of these will be allowed **ONLY** during our "Low Mobility Week" each summer.

MEDICAL CONDITIONS:

1. Seizure-controlled (**NO MORE than 1 seizure per month**).
2. Able to eat most normal adult table food (controlled diabetics acceptable).
3. There is limited space available for those with special dietary needs (ie Chopped or pureed diets; gluten-free, food allergies, etc.).

SELF-HELP SKILLS:

1. Uses toilet appropriately (able to wipe self, and toilet self through the night). A person with consistent issues of incontinence will **NOT** be accepted. Rare occasions of incontinence should be explained and we will accept on an individual case-by-case basis.
2. Capable of washing, dressing, and eating independently, with minimal help.
3. **WOMEN:** have an understanding and awareness of, be able to cope with, and independently provide necessary hygiene during menstrual cycle.

SOCIAL SKILLS:

1. Able to communicate needs either verbally or non-verbally.
2. Able to relate appropriately to other campers and leadership in a structured program with a 1:4 staff to camper ratio.
3. Able to function in a program involving swimming, boating, archery, etc.
4. Able to stay within physical boundaries of camp setting with no wandering
5. Free from any self-abusive or aggressive behaviors.

If you have questions, please contact the camp office BEFORE completing this application. If this is the **FIRST** year your client will be applying to attend a session at Grotonwood, you may want to contact our office to discuss the appropriateness of your client, and how your client will "fit" into the program we offer. Please call the camp office at 978-448-5763 and ask to speak to the Registrar, the Special Needs Coordinator, or the Resident Director.

I have read the above, and this camper meets, or exceeds, the listed minimum abilities. Please sign below.

Signature of Adult Camper and/or Parent/Guardian/Caregiver

Date

UNDERSTANDING THE CAMPER:

Primary Diagnosis: _____ Degree of Mental Retardation: () Mild () Moderate () Severe

Physical Disability (Describe) _____

Does the camper have: () Mobility Impairment () Hearing Impairment () Epilepsy () Diabetes
 () Autism () Cerebral Palsy () Seizure Disorder () Visual Impairment
 () ADHD/ADD () Other: _____

Is the applicant able to participate in the normal pace of activities (i.e. walking, hiking, sports, swimming, etc.) or do exceptions need to be made for a slower pace (most rest, sitting out of some activities, etc.?)

() Little or no rest between activities () Some rest between activities () A lot of rest between activities

PERSONAL

Has camper ever attended Grotonwood? () YES () No When? _____
 Has camper ever been away from home before? () YES () No
 Are problems with homesickness anticipated? () YES () No If yes, what might be the best way of handling it? _____

Activities

	Enjoys	Does NOT Enjoy	CANNOT Participate		Enjoys	Does NOT Enjoy	CANNOT Participate
Swimming				Dancing			
Pontoon Boat				Archery			
Hiking				Tubing			
Rock Wall				Paddle Boats			
				Ball Games (kickball, basketball)			

Please list any activities NOT mentioned above that the camper especially **DISLIKES**: _____

Please list any activities NOT mentioned above that the camper especially **LIKES**: _____

BEHAVIOR & PEER RELATING:

Check those behaviors that apply to the camper:

- No unusual behavior
- Physically aggressive towards others
- Physically aggressive towards objects
- Verbally aggressive
- Withdrawn/Shy
- Stubbornness
- Self-Injurious
- Attaches to MALE Staff
- Attaches to FEMALE Staff
- Temper Tantrums
- Wanders/Runs Away
- Other (Please Describe): _____

Is camper on a behavior management plan? () Yes () No If "yes," attach a copy of the program

Explain all checked behaviors, their frequency, and method/interventions of dealing with behaviors: _____

Does camper have any strong fears, such as animals, thunderstorms, height, water, etc. () Yes () No If "yes" please explain method for dealing with fears: _____

Please list any other information you would feel helpful in providing the best camping experience: _____

SPEECH: () Normal () Mildly affected () Moderately affected
() Severely affected () Few Words () Non-Verbal

COMMUNICATION:

Can camper communication wants/needs? () Yes () No
Method of communication: () Verbal () Sign Language () Communication Board () Points, Grunts () Gestures () Other: _____
Does camper understand and respond to yes/no questions? () Yes () No
Is camper able to communicate pain? () Yes () No
Further communication instructions and assistance required: _____

HEARING: () Normal () Hard of Hearing () Partial loss
() Total Loss () Wears hearing aid(s)

If camper has partial or total loss, please explain the best way to communicate with him/her: _____

COMMUNICATION AND MEMORY: Knows own name () Yes () No
Oriented to Place () Yes () No Oriented to Time () Yes () No
Follows Directions () Yes () No
Please explain any "no's" or how to best help the camper adjust to the daily schedule of camp: _____

MOBILITY:

Does the camper require assistance in walking? () Yes () No
If yes, does the camper use: () Support from another person () Cane () Walker () Crutches () Other: _____
Describe gait: () Stable () Walks Slowly () Falls Easily () Unsteady
Does camper use a WHEELCHAIR? () Yes () No () For long distances (please provide): () Manual () Electric
How does camper transfer to and from wheelchair? () Independently () With arm support () Pivot () 2-person lift () Hoyer Lift () Other: _____
Can camper support weight in transferring? () Yes () No
Does camper's mobility level restrict him/her to the FIRST FLOOR? () Yes () No
If ambulatory, can camper walk up/down stairs unaided? () Yes () No If not, please explain: _____

ADAPTIVE DEVICES: Please take the time to check off and SEND any of the adaptive device(s) the camper uses on a regular basis: () None () Helmet () Hearing Aid(s) () AFO's or night braces () Glasses () Dentures () Prosthesis () Contacts () Other: _____

Please provide specific instructions on use and care of adaptive devices.

Eating: Assistance Level: () Totally Independent () Can Feed Self Finger Foods () Needs help (cutting/pouring)
 () Cannot Feed Self () Other/Explain: _____
 Is camper's diet: () Normal () Diabetic () Low-Salt () Low Cholesterol () Low-Fat () Other: _____
 Is camper on a medically-prescribed diet or restrictions? () Yes () No If yes, describe or send sample diet menu: _____
 Camper does NOT Eat: () Beef () Seafood () Eggs () Pork () Dairy Products () Other: _____
 Does camper have difficulty: () Swallowing () Chewing () Drinking
 Does camper REQUIRE: () Special utensils (please bring) () Chopped Food () Blended/Pureed Food () Straw
 () Diet Supplement (i.e. Ensure; Please bring) () Other: _____
 Does camper have any FOOD ALLERGIES? () Yes () No If yes, describe what they are allergic to: _____
 Reactions to Food Allergy: () Hives () Difficulty Breathing () Anaphylaxis () Other: _____
 Further eating instructions: _____

Sleeping Patterns: () Normal () Restless () Hard to Wake () Talks in Sleep () Wanders/ Sleepwalks
 () Incontinence () Other: _____
 On average, how many hours does the camper sleep? _____
 Does camper need bed rails? () Yes () No Does the Camper need a nightlight? () Yes () No
 Does camper have any bedtime rituals? () Yes () No Please Describe: _____
 Further Sleeping Instructions: _____


Grooming:
Dressing: () Independent () Verbal Prompts () Some Help () Total Help
 If help is needed, please check off the item(s) the camper needs help with: () Buttons () Shoes () Shoe Laces
 () Socks () Fasteners () Zippers () Shirt () Pants () Underwear/Bra () Other: _____
 Further Dressing Instructions: _____

Showering/Personal Care: () Independent () Verbal Prompts () Some Help () Total Help
 Does camper need assistance with: () Washing face and hands () Showering () Washing Hair () Washing Back
 () Brushing Teeth () Combing Hair () Shaving () Menstrual Care () Other: _____
 Further Personal Care Instructions: _____

Bathroom Use: Does the camper need assistance in the bathroom? () Yes () No Verbal Reminders? () Yes () No
 Please explain bathroom assistance needed: _____
 Does the camper wear Attends/Briefs during the day? () Yes () No During the night? () Yes () No **(Please send plenty. If not, you will be billed for our expense)**
 Is the camper on a bathroom schedule during the day? () Yes () No During the night? () Yes () No
 Please explain: _____
 Check items camper uses **(Please bring these items):** () Urinal () Bedpan () Catheter - Type: _____
 Further bathroom instructions: _____

Waiver & Release

This document must be signed by either a parent or legal guardian, if applicable. All references to the camper include the parent or legal guardian. As a condition to participating in the summer camp and weekend programs, the camper agrees to the following: Camper acknowledges that a wide variety of activities will be conducted, including swimming. Camper acknowledges that some of the activities may subject him/her to certain stresses and hazards not all of which can be foreseen. Camper desires and consents to take part in all such activities unless otherwise indicated in writing prior to the summer and weekend camp program. Camper assumes all risks incident to the nature of the activities to be conducted and agrees that Grotonwood, nor any of its representatives shall be held responsible for any damages or injuries to the camper. Camper understands that Grotonwood reserves the right to dismiss any camper from further participation in the program in the event the program staff determine that the camper cannot meet the program eligibility requirements. Supervision and transportation resulting from dismissal are the responsibility of the camper. If a camper is sent home for behavioral reasons, there is NO refund of the camp fees. Refunds are given on a pro-rated basis, if a camper must leave early for medical reasons. Camper understands that Grotonwood and its representatives are not responsible for loss or damage to the personal property and possessions of the camper. Camper is liable for any damage to the property of Grotonwood resulting from the acts of the camper. Camper consents to the use of any film/photographs/video taken during the program, whether for advertising, promotion, and/or publicity purposes by Grotonwood unless otherwise indicated in writing prior to the program. The camper waives all claims of compensation for such use. Permission is granted for camper to attend all program field trips upon notification. Camper represents that all of the information provided on this application, including the health/medical forms, is true and correct and that Grotonwood and its representatives have the right and authority to rely on the information contained therein. Camper further recognizes that Grotonwood and its representatives reserve the right to reject any participant in the event of the failure or refusal of the participant to accurately complete and sign all of the required documents. **I have read and fully understand the program details, waiver and release.**

 **Signature of Camper 18 yrs. or older** _____ **Date** _____
Signature of Parent/Legal Guardian _____ **Date** _____

2016 SPECIAL NEEDS CAMPER MEDICAL RECORD: GROTONWOOD

IMPORTANT: This application will not be considered if it is returned incomplete, or without the Application and **required deposit**. The Parent/Legal Guardian, adult camper or staff member must fill in the following information. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel before or upon arrival at camp. Provide complete information so that the camp can be aware of your needs. **PLEASE PRINT NEATLY THROUGHOUT. Don't forget to SIGN THE LAST PAGE! It is REQUIRED!**

CAMPER INFORMATION (Note: This is the address ALL correspondence will be mailed to)

Camper's Name: _____

Phone Number: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

() Male () Female Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Social Security #: _____

CONTACT INFORMATION (During the Year AND While at Camp)

Contact Person #1: _____ Day Phone: _____

Relationship to Camper: _____ Night Phone: _____

If not available, please call:

Contact Person #2: _____ Day Phone: _____

Relationship to Camper: _____ Night Phone: _____

Person/Agency Responsible for Transportation

Name: _____ Phone: _____

INSURANCE INFORMATION

Insurance coverage for accidents or illness while participating at Grotonwood is the responsibility of the camper and/or their family. Grotonwood has coverage for any camp-related accidents for which the total of all charges is \$250 or less. Situations in excess of \$250 are the responsibility of the individual's own insurance.

Carrier: _____ Policy or Group No. _____

Medicare No. _____ Medicaid No. _____

Address of Carrier: _____ City: _____ State: _____ Zip: _____

MEDICAL HEALTH HISTORY

Primary Diagnosis: _____

Degree of Mental Retardation: () None () Mild () Moderate () Severe

Physical Disability (Describe): _____

Does the Camper Have: () Mobility Impairment () Hearing Impairment () Epilepsy () Diabetes () Autism

() Cerebral Palsy () Seizure Disorder () Visual Impairment () ADD/ADHD () Other: _____

Allergies: Please list any known allergies and the allergic reaction the camper may have:

MEDICATION ALLERGIES: _____

FOOD ALLERGIES: _____

OTHER ALLERGIES: _____

Diabetes Does the camper have a history of Diabetes? () Yes () No
If YES, how is it controlled? () Insulin Dependent () Oral Medication () Controlled by diet alone (please send a sample day's menu).
Is blood sugar testing required? () Yes () No (if yes, please remember to send the appropriate equipment and supplies)

Seizures Does the camper have a history of seizures? () Yes () No
If yes, date of last seizure? _____ What type(s) of seizures? _____
How many in the past six (6) months? _____ Duration of seizures? _____
Are there any triggers? _____
Describe behavior before: _____
During: _____
And after the seizure: _____
Protocol normally followed: _____

Check if individual is subject to any of the following:

- () Sunburn () Frequent Colds () Dizziness/Fainting () Constipation () Sinus Infection
() Frostbite () Bronchitis () Asthma () Ear Infection () Nausea/Vomiting
() Diarrhea () Vaginal Infections () Sore Throat () Pneumonia () Urinary Infections
() Skin Rash () Hernia () High Blood Pressure () Frequent headache
() Back Problems () Joint Problems () Chest pain during/after exercise () Bed wetting/incontinence

Camper MUST: () NOT get water in ears () Stay OUT of water () Wear Ear Plugs when swimming (bring)
Has the Camper: () Been Hospitalized () Ever had surgery () Ever had a head injury
Please comment on the above checked items for treatment given: _____

Recommendations and Restrictions while at camp:

Any medically-prescribed meal plans or dietary restrictions: _____
Does NOT eat: () Beef () Seafood () Eggs () Pork () Dairy Products () Gluten () Peanuts/Tree Nuts
() Other: _____
Please explain any dietary restrictions or ALLERGIES the camper may have: _____

Activity Restrictions:

A wide variety of programs are offered at Grotonwood, including those listed below. Please indicate from which activities the camper should be **restricted**.

- Swimming: () OK to participate () CANNOT Participate
Pontoon Boat () OK to participate () CANNOT Participate
Paddle Boats () OK to participate () CANNOT Participate
Hiking () OK to participate () CANNOT Participate
Archery () OK to participate () CANNOT Participate
Rock Wall () OK to participate () CANNOT Participate
Tubing () OK to participate () CANNOT Participate

Please list any other activities from which you feel the camper should be **RESTRICTED**: _____

MUST be accurate and up-to-date within the previous 24 months; AND, MUST be signed by the doctor (or attach his/her form)

PHYSICAL EXAMINATION

CAMPER NAME: _____ Attending Session(s): _____

The Physical Examination form MUST BE completed and signed by a LICENSED PHYSICIAN. EXAMINATION COMPLETED BY DOCTOR, within the previous 24 months. DATE OF EXAM: _____

Height:	Weight:	Pulse:	BP:	Temp:
Head/Scalp		Lungs		
Eyes		Cardiac		
Vision		Upper Extremities		
Ears/Hearing		Lower Extremities/Edema/Circulation		
Mouth/Throat/Nose		Back/Spine		
Neck/Thyroid/Lymph Sys.		Perineum		
Nervous Sys./Pupil Reaction/Reflexes/Gait/Sensations		Skin		
Breast Exam:	Pap Smear:	Abdomen		
Testes Exam:				

VACCINATIONS

Tetanus/Diphtheria Booster _____
 Rubella Vaccine: _____
 Mumps Vaccine (if born after 1956) _____
 Measles Vaccine (if born after 1956) _____
 Date of last TB Mantoux Test: _____

WHAT IS THE CAMPER'S

Normal Blood Pressure: _____
 Normal Pulse: _____
 Normal Temperature: _____

What was the result? () Positive () Negative

PROBLEM

PAST

PRESENT

EXPLANATION

Tuberculosis	()	()	_____
Hepatitis B	()	()	_____
Bleeding Disorders	()	()	_____
Rheumatic Fever	()	()	_____
HIV Positive	()	()	_____
Heart Disease	()	()	_____
Other: _____	()	()	_____

ACTIVITY RESTRICTIONS:

List any conditions, operations or known serious injury that may affect activity level: _____

Are there medical reasons to limit or restrict this camper from participating in the SWIMMING PROGRAM? () Yes () No

If yes, please explain: _____

PLEASE list any other activity restrictions while the individual is participating at camp:



Examining Physician's Name (Print) _____
Signature: _____ Date: _____
Address: _____ Phone: _____

NOTE: In the event of illness or injury occurring after this physical report, a descriptive note written by the caregiver and/or physician MUST be sent prior to the participant's arrival at camp.

MEDICATION RECORD

IMPORTANT -- PLEASE READ AND SIGN BELOW, even if you take NO Medications!

It is vitally important that all **PRESCRIBED MEDICATIONS** are brought to camp in their **ORIGINAL PACKAGING** from the **PHARMACY**, with the **CAMPER'S NAME** and **DOCTOR'S NAME** clearly visible on the label. Campers **WILL NOT BE PERMITTED TO STAY** if medications are pre-packaged in any type of cassette, baggies, envelopes, etc. While at camp, all medications are administered by the camp nurse, except for prescription creams, shampoos, or oral rinses. For these exceptions, the nurse will oversee the administrations of the medication. **I have reviewed this completed Camper Health Form. It is correct and complete, and the camper herein described has permission to engage in all activities except noted.**

I give permission to the camp nurse and/or physician to administer any necessary first aid should a situation requiring medical attention occur while at camp, and IN CASE OF EMERGENCY, give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery. Grotonwood has accident and sickness insurance (including any ambulance transportation which may be required) for the first \$250 of a claim. Amounts over \$250 are the responsibility of the individual's primary insurance.

I give permission to the camp nurse to administer prescriptions (as noted below) and over-the-counter medication (PRNs) brought to camp.



SIGNATURE: _____ DATE: _____

PLEASE NOTE:** Camp Nurse **MUST** be notified if the below medications **CHANGE** between the time application is submitted and the actual camp date. A **COPY** of the physician prescription along with the detailed and complete written instructions **MUST** accompany camper upon arrival at camp. **ATTACH ADDITIONAL SHEETS AS NECESSARY.**

<input type="checkbox"/>	THIS CAMPER DOES NOT TAKE ANY MEDICATIONS ON A ROUTINE BASIS, and comes to camp with NO Meds.
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NAME of Drug (Exactly as Dispensed)	Dosage Amount	Camp Times Given (8am, 12 pm, 4 pm, 8pm)	Directions for Administration	Reason(s) for Medication
Example: Mellaril <i>Sample</i>	50 mg <i>Sample</i>	8am,8pm <i>Sample</i>	One Tablet, 2 times a day. Crush pill	Behavior <i>Sample</i>

PLEASE CHECK ALL THAT APPLY: () Swallows meds. whole () crush meds. () uses oral syringe (please send)
 () Uses med. spoon (please send) () Takes with applesauce (please send a supply)

SCREENING RECORD (FOR GROTONWOOD use ONLY)

Date:	Time of Screening:
Medications Received/Amount:	
Updates/Additions to Health History:	
Current Health Needs Identified	
Observation Notes:	
Screened By:	